

Disabled Persons and Family Support Application

Date _____ Applicant/Person with Disability Please check: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss Name _____ <hr/> Address _____ City/State/Zip Code _____ County _____	Assisting with this form, i.e. Parent/Guardian/Representative Name _____ Relationship to applicant _____ Address _____ City/State/Zip Code _____ Phone _____ E-mail _____																												
Home Phone _____ Work Phone _____ E-mail _____	Referral Source Name _____ Agency/Organization _____ Address _____ City/State/Zip Code _____ Phone _____ E-mail _____																												
Date of birth _____ Social Security Number _____	City/State/Zip Code _____ Phone _____ E-mail _____																												
What is your disability? How does your disability impact your daily living activities?	Case Manager or Services Coordinator • Name _____ Agency/Organization _____ Phone _____ • Name _____ Agency/Organization _____ Phone _____																												
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• Services and Devices Requested

(check all that apply)

- ☐ Home Modifications
- ☐ Purchase or refinance a home
- ☐ Personal attendant
- ☐ Meals and lodging
- ☐ Home health care
- ☐ Housekeeping service
- ☐ Prescriptions
- ☐ Respite care
- ☐ Special equipment/assistive devices
- ☐ Transportation
- ☐ Other _____

• Housing (check all that apply)

- ☐ Home Owner
- ☐ Renter
Landlord _____

Address _____

City/State/Zip _____

Phone _____

- ☐ Nursing home
- ☐ Foster home/adult family home
- ☐ Group home/community residence
- ☐ Living with adult/adult children
- ☐ Homeless
- ☐ Other _____

Type

- ☐ Single family unit
- ☐ Multi-family unit-number of units _____
- ☐ Mobile home
- ☐ Other _____

Assistance received from:

- ☐ League of Human Dignity, Barrier Removal Program
- ☐ Housing and Urban Development, Section 203
- ☐ Making Homes Accessible (MHA)
- ☐ Rural Development, Section 502
- ☐ Rural Development, Section 504
- ☐ Weatherization
- ☐ HomeChoice

• Personal

(check all that apply)

Veteran Status

- ☐ Veteran
_____The person with a disability is a veteran
_____The spouse of applicant with a disability is a veteran
_____The parent of applicant with a disability is a veteran
- ☐ Veteran was in military service during a war
- ☐ Veteran has a service-connected disability
- ☐ Veteran is a resident of Nebraska
Dates of service _____

Citizen of U.S.

- ☐ Yes ☐ No

Insurance

- ☐ Health Insurance

Specify _____

- ☐ Medical Assistance/Medicaid
- ☐ Medicare

Assistance

Check any of the following that have provided assistance to you (i.e. information, referral, or funding) during the last year:

- ☐ Area Agency on Aging
- ☐ Hotline for Disability Services
- ☐ Independent Living Center
- ☐ Nebraska Assistive Technology Partnership
- ☐ Nebraska Commission for the Blind and Visually Impaired
- ☐ Nebraska Commission for the Deaf and Hard of Hearing
____ Assistive listening devices
____ Decoder loan
____ Hearing aid bank
____ TDD loan
- ☐ Nebraska Educational Assistive Technology (NEAT)
- ☐ Nebraska Health and Human Services
____ Developmental Disabilities
____ Disabled Persons and Family Support
____ Medicaid Waiver
____ Medically Handicapped Children's Program
____ Mental health services
____ Social Services Block Grant
- ☐ Nebraska Veterans' Aid Fund
- ☐ Paralyzed Veterans of America Education Center
- ☐ United Cerebral Palsy of Nebraska
- ☐ Veterans Service Office
- ☐ Vocational Rehabilitation
- ☐ Other _____

• Financial Information

List the amount of income you receive (i.e. your family) from each of the sources below. Single adults (19 years of age or older with no minor children) should list only your income. Families should list income of married couples or income of all adults, including wages of children ages 14-18.

Gross Income (your income before deductions)	Amount	How often received	Who receives it
Wages, overtime, bonuses, commissions, etc.			
Self-employment (use current IRS 1040)			
Interest dividends, money from investments and capital gains			
Social Security Retirement			
Social Security (SSI)			
Social Security Disability			
Veteran's Benefits			
Pensions			
Retirement, Keogh Accounts, IRA's, etc.			
Inheritance, estates, trust funds, etc.			
Aid to Aged, Blind and Disabled (State Supplemental Check)			
Aid to Dependent Children (ADC)			
Alimony/Child Support			
Compensation (worker's and unemployment)			
Rental income and boarders			
Miscellaneous (insurance settlements, lottery winnings, and other, please describe)			
Assets List assets that are readily available (e.g. cash, checking accounts, stocks, bonds, whole life insurance, certificates of deposit, farmland, etc., and any liquid assets that can be converted to cash without incurring a substantial tax penalty for early withdrawal)			Amount
Expenses related to your disability (e.g. medication, doctor bills, transportation to the doctor, special equipment, etc.)			Amount

• **Release/Agreement Form**

I verify that the information provided on this application is correct and complete.

I understand that whenever changes occur in the information provided, I need to report them immediately to one of the agency/agencies helping me obtain devices or services.

I understand I have the right to appeal if I am not satisfied with an agency's action.

I understand that this is a **multi-agency form**. The agencies/programs listed below may contact each other to determine my financial eligibility for their programs, and may verify my need for the support for which I have applied. I authorize the release of this information to be used for referrals/services for which it is determined I may be eligible. It is my understanding that this information will be held confidential by all the agencies listed.

- Client Assistance Program
- Hotline for Disability Services
- Independent Living Centers
- * Making Homes Accessible (MHA) Program
- Muscular Dystrophy Association
- Nebraska Advocacy Services
- Nebraska Assistive Technology Partnership and Peer Support Network
- Nebraska ChildFind
- Nebraska Commission for the Blind and Visually Impaired
- Nebraska Commission for the Deaf and Hard of Hearing
- Nebraska Department of Health and Human Services
- Nebraska Easter Seal Society
- Nebraska Department of Veterans' Affairs, Nebraska Veterans' Aid Fund
- Nebraska Educational Assistive Technology (NEAT)
- Nebraska Home of Your Own Coalition
- Paralyzed Veterans of America Education Center
- The Arc of Nebraska
- United Cerebral Palsy of Nebraska
- Vocational Rehabilitation
- Other _____

Information may be released and shared on my behalf with the following family members and individuals:

Signature of applicant (or guardian)

Date

The following information is being requested for Federal reporting purposes only. Your response is optional and will not affect your eligibility determination. We would appreciate your assistance by providing a response.

Ethnicity/race (please check)

- ☐ White (non Hispanic) ☐ Black (non-Hispanic) ☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander
- ☐ Hispanic ☐ Multi-Racial ☐ Other _____

Return this form to: Home & Community Services
Disabled Persons and Family Support
P.O. Box 95025
Lincoln, Nebraska 68509-5025